NOTICE OF DISPUTED ISSUE(s) AND REFUSAL TO PAY BENEFITS

DATE:

TO: **[NAME OF INJURED EMPLOYEE]**
[ADDRESS]
[CITY, STATE, ZIP]

RE: **[DATE OF INJURY]**
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM #]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP]

We are disputing entitlement of (***type of benefit/service/body part/condition***) because:

(***Provide full and complete statement explaining the action taken_________________
____
____***)

If you do not agree with the dispute and refusal to pay benefits, please contact me:

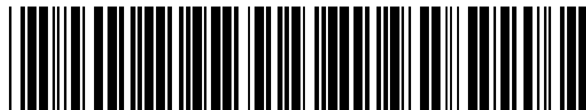
Adjuster's Name: ____
Toll Free Telephone #: ____
Fax #/E-mail Address: ____

If we are unable to resolve the issue to your satisfaction, you have the right to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation and request a Benefit Review Conference. For assistance or to request a Benefit Review Conference, contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or electronic transmission such as e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:



INSTRUCTIONS:

Notification of Disputed Issue(s) and Refusal to Pay Benefits (DWC FORM PLN-11) Rule 124.2(h)

This letter will be used to notify the employee and the Division of the carrier's dispute of an issue dealing with the administration of a claim (disability, extent of injury, etc). This letter does not constitute a request for a Benefit Review Conference. This letter should be used to identify the existence of a benefit disputed issue to include, but not limited to, disability, extent of injury, or the eligibility to Death Benefits of a beneficiary or potential beneficiary and should be provided to the employee/beneficiary/representative.

If the initial determination is that the entire claim is not compensable, see DWC FORM PLN-1.

Provide a full and complete statement of the facts surrounding the claim that justify and serve as the grounds for the dispute.

EXAMPLES:

- Your entitlement (***medical treatment for the neck, shoulder and arm***) is being disputed and benefits are not being paid for the following reason(s):

- We have received notice of an injury to additional body parts. We dispute the additional body parts of neck, shoulder and arm as not related to the compensable injury sustained 5/1/02. The employee has not previously mentioned these body parts as part of the injury and there is no medical evidence to support a causal relationship to the compensable injury.

NOTE:

A statement that simply states a conclusion such as "disability in question", "carrier disputes extent" or "under investigation" is insufficient grounds for the information required per Rule 124.2(h).

Disputes should be based upon information a carrier has obtained or verified.

MAIL THIS LETTER TO THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION IN LIEU OF A DWC FORM-21